



## Missouri Pharmacy Program – Preferred Drug List



### Inhaled Corticosteroids

**Effective 07/11/2013**

**Revised 07/09/2015**

#### **Preferred Agents**

- Advair HFA/Diskus®
- Asmanex®
- Dulera®
- Flovent HFA/Diskus®
- Pulmicort® Flexhaler
- QVAR
- Symbicort®

#### **Non-Preferred Agents**

- Aerospan®
- Alvesco®
- **Arnuity Ellipta®**

<b><u>Approval Criteria</u></b>	<b><u>Denial Criteria</u></b>
<ul style="list-style-type: none"><li>• Failure to achieve desired therapeutic outcomes with trial on 4 or more preferred agents<ul style="list-style-type: none"><li>○ Documented trial period for preferred agents</li><li>○ Documented ADE/ADR to preferred agents</li></ul></li></ul>	Lack of adequate trial on required preferred agents
<ul style="list-style-type: none"><li>• Documented compliance on current therapy regimen</li></ul>	Therapy will be denied if no approval criteria are met
	Drug Prior Authorization Hotline: (800) 392-8030